LICENSED CHILD CARE CENTER / HOME MONTHLY REPORT AS REQUIRED BY IC 12-17.2-2-1.5 State Form 50550 (R3 / 7-06) / BCC 0079
AS REQUIRED BY IC 12-17.2-2-1.5

☐ CENTER	
☐ HOME	

NAME OF CHILD	BIRTHDATE	DATE ENROLLED Indicate By Check Mark ( ⁄ )	DATE WITHDRAWN Indicate By Check Mark ( √ )	VERIFICATION OF BIRTHDATE COMPLETED BIRTH CERTIFICATE INFORMATION REQUIRED Indicate by Check Mark (√)	PARENTS PERMISSION FORM SIGNED Indicate by Check Mark (√)

Name of facility / licensee	
License number	

## PLEASE SUBMIT THIS FORM TO:

MS 02 Division of Family Resources 402 West Washington Street, Room 386 Indianapolis, IN 46204-2739

Date form completed (month, day, year)	
Signature of person completing this form	